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VENEREAL DISEASES IN ENGLAND AND WALES*

EXTRACT FROM THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR THE YEAR 1958

VENEREAL DISEASES

The principles which govern the operation of the venereal disease treatment centres were established by the Public Health (Venereal Diseases) Regulations of 1916, and the venereal diseases scheme was in being 30 years before the National Health Service Act was passed. In the intervening years the scheme, under the control of the Local Authorities, had given notable service to the public, and had made major contributions to the control of venereal diseases and to the acquisition of new knowledge concerning them. When the National Health Service Act came into operation in 1948, the long-established principles governing the operation of the centres were confirmed, even though the Venereal Diseases Regulations were revoked, and no more than minor administrative changes were required to fit the scheme into the general picture. During the last 10 years it has been more and more appreciated that the subject of venereology, although it has its roots in various branches of medicine, is a composite whole by virtue of the psychological problems which are common to its patients, and of the particular responsibility which the venereologist has in the field of preventive medicine. Improved status and detachment from interests which compete for attention have led to improvement in standards and to the recruitment of young physicians of high quality. The change in administration coincided with a period of settled social circumstances leading to diminution in the incidence of venereal disease, with the consequence that the past 10 years have been a period of contraction rather than expansion of this service. The wisdom of limiting that contraction to the minimum has become evident with the increase in incidence of some venereal diseases during the past few years.

Syphilis.—In 1958 there was a further fall in the number of cases of early infectious syphilis attending the clinics for the first time (Appendix, Table B); but the Table which follows, showing the numbers of these cases in ten urban areas, indicates that the decline was not consistent throughout the country. There was an appreciable increase in the Merseyside area and some increase also in Manchester and Tyneside. The figures for Birmingham show no reduction and those for London very slight reduction.

EARLY SYPHILITIC INFECTIONS DEALT WITH FOR THE FIRST TIME IN 1957 AND 1958 IN TEN SAMPLE AREAS

Urban Areas	1957			1958		
	Males	Females	Total	Males	Females	Total
London Administrative Area (3,225,000)* ..	221	80	301	202	96	298
Merseyside (Liverpool, Bootle, Birkenhead, Wallasey) (1,089,450)	51	3	54	77	7	84
Manchester and Salford (840,500)	2	1	3	9	2	11
Tyneside, (Newcastle, South Shields, Tynemouth) (449,700) ..	6	1	7	7	4	11
Hull (301,100)	6	1	7	3	1	4
Southampton (199,940)	23	3	26	14	1	15
Bristol (438,000) ..	21	5	26	18	1	19
Birmingham (1,095,000)	13	7	20	18	2	20
Leeds and Bradford (799,400)	11	3	14	8	2	10
Sheffield (498,800) ..	8	4	12	8	3	11

* The figures in brackets are the estimated population at June 30, 1958.

The number of new patients in the later stages of the disease is also appreciably fewer than in 1957, but it must be remembered that many patients suffering from cardiovascular syphilis and neurosyphilis are treated elsewhere than at the clinics. No estimate of their numbers is possible, but it seems probable that simplification of the treatment of syphilis has led to an increase in the proportion so treated. The Table below also shows that the number of patients in "other late and latent stages" has likewise fallen considerably, in spite of the fact that large numbers of immigrants from areas where syphilis is still relatively common attend the clinics

* Part II of the Report of the Ministry of Health for the year ended December 31, 1958. Cmnd. 871, p. 59. Appendix C, p. 252.

for other conditions, and all are tested serologically as a routine. It is also of interest that 280 cases of yaws were diagnosed at the clinics during 1958.

Late Syphilis	Year	Males	Females	Total
Cardiovascular Syphilis ..	1957	249	118	367
	1958	220	92	312
Neurosyphilis	1957	394	215	609
	1958	397	177	574
All Other Late or Latent Stages	1957	1,345	1,352	2,697
	1958	1,205	1,094	2,299
Total Late or Latent Syphilis	1957	1,988	1,685	3,673
	1958	1,822	1,363	3,185

The Registrar General's figures for 1958 show that deaths from general paralysis of the insane have shown some increase, but those from tabes dorsalis and aneurysm of the aorta have declined. Decline in the number of males dying from aneurysm of the aorta has been partially offset by increase in the number of females (Appendix, Table E).

The number of new cases of congenital syphilis in infants of less than one year has again fallen, to 17 as against 27 in 1957. These figures are very satisfactory, but it is likely that some infected babies escape treatment or are treated by paediatricians. It cannot be said too often that antenatal blood tests provide the means of almost complete elimination of congenital syphilis, and it is regrettable that such tests are not yet routine practice outside the antenatal clinics of hospital and public authorities. There has been a further fall in cases of late congenital syphilis (Appendix, Table C), and it is gratifying to learn that interstitial keratitis, which was not at all unusual until recently, is now rarely seen at the clinics.

Testing for Syphilis in Pregnancy.—Results of routine serological tests for syphilis on blood from pregnant women have been received from six regional blood transfusion centres and are shown in the following Table:

A summary of the results of tests from primiparae and multiparae for the past 6 years (shown below) reveals a slight decrease in the percentage of positive tests in both primiparae and multiparae in 1958.

Year	Primiparae		Multiparae	
	No.	Percentage Positive	No.	Percentage Positive
1953	28,263	0·21	27,573	0·43
1954	39,181	0·23	47,941	0·23
1955	41,392	0·21	40,712	0·43
1956	48,420	0·28	40,295	0·35
1957	49,914	0·14	43,730	0·29
1958	49,315	0·13	40,765	0·23

Gonorrhoea.—The steep rise in the number of new cases of gonorrhoea in both sexes has continued. It gives cause for anxiety. The figures are the highest since 1948 (Appendix, Table A). Though the rise is fairly general throughout the country, it is most marked in London and in certain other areas where immigrants from overseas are numerous. In a few of these districts, however, the rise in incidence has not continued. The consultant in charge of the clinics in Birmingham has suggested that a decline in the re-infection rate among his immigrant patients might indicate that some of them are achieving a more stable existence. It must be understood, however, that recurrence of gonorrhoea does not invariably mean re-infection, even after re-exposure; the possibility of true relapse has now to be considered more often than formerly. Penicillin remains an effective remedy for this disease, but there has been a general tendency to increase the dosage which many venereologists have doubled or even trebled during the last few years. Even so, failures and relapses after treatment are quite common and there is reason to suppose that some patients who discontinue attendance after their symptoms have subsided are harbouring latent infection. Meanwhile, at the request of the Ministry, a Committee of the Medical Research Council is investigating the problem of the sensitivity of the gonococcus to penicillin.

CASES OF ANTENATAL SYPHILIS, 1958

Regional Blood Tranfusion Centre	No. of Antenatal Patients Tested			Positive Syphilis Tests				
	Primiparae	Multiparae	Parity not known	Primiparae		Multiparae		Parity not known
				No.	Per cent.	No.	Per cent.	No.
Leeds	8,516	7,590	3,570	8	0·09	19	0·25	2
Sheffield	14,655	8,125	—	24	0·16	33	0·41	—
Liverpool	18,662	16,519	—	22	0·12	23	0·14	—
Plymouth*	2,046	2,096	—	5	0·24	10	0·48	—
Oxford	1,655	1,729	184	1	0·06	2	0·12	—
Cambridge	3,781	4,706	4,523	3	0·08	7	0·15	4

* In addition nine "doubtful" results were recorded in primiparae and ten in multiparae.

In London and in some provincial cities, prostitutes, or "near prostitutes" continue to be responsible for the spread of much infection, and the tracing, treatment, and follow-up of these girls present a serious social as well as a medical problem.

It will be appreciated that "new cases" and "new patients" are not synonymous terms. The patient who has two attacks of a disease in the course of a calendar year appears in the annual return as two cases. The Table below shows that, in seven important clinics (four in London and three in the provinces), the number of cases of gonorrhoea in 1957 was considerably larger than the number of patients suffering from the disease, indicating that re-infection accounted for many of the new cases. Most of these re-infections, though by no means all, occurred among immigrants from overseas and other migrants.

GONORRHOEA, 1957

Clinic	Cases		Patients	
	Males	Females	Males	Females
London Hospital	1,196	412	930	398
St. Mary's Hospital ..	2,228	513	1,429	467
SS. Peter's and Paul's Hospital	802	146	519	126
St. Thomas's Hospital ..	792	167	790	160
General Hospital, Birmingham	1,071	187	957	185
St. Luke's Clinic, Manchester	1,080	282	862	232
General Hospital, Newcastle upon Tyne	362	84	320	79

At H.M. Prison, Holloway, the consultant venereologist reports that the number of known prostitutes admitted, many of them on remand for a few days, increased from 292 in 1957 to 464 in 1958. The number of these in the age group 15 to 20 years was doubled and accounted for 36 per cent. of the total number of prostitutes admitted to this prison. As usual, there was a very high incidence of infection among these women; 23 cases of syphilis and 159 of gonorrhoea were found among them and, in addition, there were 230 cases of vaginal discharge. Many of these patients could be harbouring gonococci and required further investigation, but they left prison before this could be carried out.

Other Venereal Diseases.—New cases of chancroid are virtually unchanged at 259 as against 260 in 1957, and there were 77 cases of lymphogranuloma venereum as compared with 76 cases in 1957. Granuloma inguinale, which was almost unknown in England and Wales until the last few years, remains at much the same level, with nineteen cases in 1958 as against twenty in 1957. Non-gonococcal urethritis in men has shown a further increase, from 16,066 in 1957 to 17,606 in 1958, and it is noteworthy that the number of women with "other conditions needing treatment" has also risen (Appendix, Table A). Most of these women complain of vaginal discharge and many of them are found to be contacts of men known to be suffering from non-gonococcal urethritis. Some of them, however, are contacts of men infected with gonorrhoea and may well be harbouring gonococci which so often cannot immediately be demonstrated by direct microscopic tests. Though in the past there has often been difficulty in arranging for satisfactory cultures in small clinics remote from pathological laboratories, this can now usually be overcome by the provision of suitable transport medium. The importance of a readily available and efficient cultural technique in the diagnosis of gonorrhoea in women cannot be too strongly stressed.

Other Conditions treated at the Clinics.—Table A of Appendix also shows that 26,711 new patients were found to need treatment for various minor genital or genito-urinary conditions, related to venereal exposure in fact or in the minds of patients. In addition, a further 30,712 were found, after examination and routine bacteriological and serological tests, to need no treatment beyond reassurance. The fact that these numbers are still high is further proof, if any were needed, of the continuing popularity of the clinics. It is clear that if asymptomatic carriers of gonorrhoea or other infections are to be detected, the net must be cast as widely as possible.

The Present Position.—The fall in incidence of early infectious syphilis is the one satisfactory feature in the figures for 1958, particularly as there is evidence that a number of these infections occurred among visiting seamen and were contracted abroad. On the other hand, gonorrhoea in both sexes and non-gonococcal urethritis in men continue to increase, and the returns from the clinics show that the rise is becoming fairly general throughout the country. Much infection is spread by unsuspecting carriers of infection, and to trace, treat, and educate these is of paramount importance, especially in the control of gonorrhoea. In some districts it has become apparent that these essential tasks cannot be carried out properly without the help of outdoor social workers. The qualifications of such a worker should not be too rigidly defined, but one can say that personality and a natural aptitude for the work are just as important as professional "labels" of one kind or another. The clinics must be, and usually are, friendly places where patients of all walks of life and all races are not only examined and treated, but are welcomed and sympathetically handled. Their visits

to the clinics provide opportunities to enlighten them as to the true facts concerning the medical and social implications of venereal disease. These talks take time and necessitate not only adequate staff, but also suitable accommodation. It is important that private consulting rooms, as well as rooms or cubicles for examination and treatment, should be provided for this purpose.

It has been said, with truth, that an increase in venereal disease is but a single symptom of a social sickness, and it is well known that homeless immigrants, casual and itinerant workers, and children of broken homes are particularly prone to the risks which may result in infection, and they do, in fact, constitute a high proportion of patients at the clinics. Though opinions differ as to how these problems should be dealt with, it must be recognized that they are social rather than medical, and are concerned primarily with the prevention of promiscuity rather than of disease. There can be no doubt, however, that any success in solving them will result in diminution of venereal disease.

APPENDIX

TABLE A

NUMBER OF CASES (IN ALL STAGES) DEALT WITH FOR THE FIRST TIME AT ANY CENTRE, 1948 TO 1958*

Sex	Year	Syphilis	Soft Chancre	Gonorrhoea	Non-Gonococcal Urethritis (Males only)	Other Conditions†		Total Sum of Columns 2–6
	1948	9,780	706	25,006	—	56,435		91,927
	1949	7,826	543	20,366	—	52,526		81,261
	1950	5,979	433	17,007	—	55,068		78,487
						Requiring Treatment	*Not Requiring Treatment*	
Males	1951	4,506	437	14,975	10,794	11,607	26,956	69,275
	1952	3,760	389	15,510	11,552	12,578	25,928	69,717
	1953	3,272	347	15,242	13,157	13,566	25,619	71,203
	1954	2,929	301	13,962	13,279	13,071	24,651	68,193
	1955	2,711	285	14,079	14,269	13,613	24,436	69,393
	1956	2,778	307	16,377	13,825	14,254	23,514	72,055
	1957	2,747	254	19,620	16,066	14,332	23,032	76,051
	1958	2,497	247	22,398	17,606	14,562	21,711	79,021
	1948	7,349	21	5,306	—	27,462		40,138
	1949	5,873	19	4,121	—	24,801		34,814
	1950	4,988	17	3,497	—	23,840		32,342
						Requiring Treatment	*Not Requiring Treatment*	
Females	1951	3,926	16	3,089	—	8,517	12,408	27,956
	1952	3,362	14	3,585	—	8,916	11,560	27,437
	1953	2,914	9	4,021	—	9,834	10,612	27,390
	1954	2,352	8	3,574	—	10,117	9,503	25 554
	1955	2,272	10	3,766	—	10,182	9,075	25,305
	1956	2,363	9	4,011	—	10,939	8,835	26,157
	1957	2,230	6	4,761	—	11,317	9,098	27,412
	1958	1,829	12	5,489	—	12,149	9,001	28,480

* Excludes cases transferred from centre to centre. † Including non-gonococcal urethritis up to 1950.

TABLE B

CASES OF ACQUIRED SYPHILIS IN TABLE A, WITH INFECTIONS OF LESS THAN ONE YEAR, 1948 TO 1958

Year	Number		Per cent. of Table A Cases	
	Males	Females	Males	Females
1948	6,603	4,034	67·5	54·9
1949	4,392	2,420	56·1	41·2
1950	2,678	1,465	44·8	29·4
1951	1,498	774	33·2	19·7
1952	891	462	23·7	13·7
1953	755	319	23·0	10·9
1954	600	208	20·5	8·9
1955	609	228	22·5	10·0
1956	587	257	21·1	10·8
1957	555	192	20·2	8·6
1958	522	182	20·9	9·9

TABLE C

CASES OF CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME AT THE TREATMENT CENTRES, 1948 TO 1958

Year	Age (yrs)				Totals
	Under 1	1 and under 5	5 and under 15	15 and Over	
1948	372	142	215	678	1,407
1949	355	118	197	747	1,417
1950	227	141	203	652	1,223
1951	156	89	198	684	1,127
1952	110	101	191	547	949
1953	95	77	152	520	844
1954	48	41	119	478	686
1955	41	30	114	459	644
1956	36	31	82	441	590
1957	27	26	77	427	557
1958	17	15	65	340	437

TABLE D

DEATH RATES PER 1,000 LIVE BIRTHS, OF INFANTS UNDER 1 YEAR CERTIFIED AS DUE TO CONGENITAL SYPHILIS, 1948 TO 1958

Year	Rate	Year	Rate	Year	Rate
1948	0·09	1952*	0·03	1956*	0·004
1949	0·08	1953*	0·01	1957*	—
1950	0·04	1954*	0·003	1958*	0·004
1951	0·03	1055*	—		

TABLE E

DEATHS FROM GENERAL PARALYSIS OF THE INSANE, TABES DORSALIS, AND ANEURYSM OF THE AORTA, 1911 TO 1958

Year	General Paralysis of the Insane		Tabes Dorsalis		Aneurysm of Aorta*	
	Males	Females	Males	Females	Males	Females
1911–20	1,697	383	592	106	838	208
1921–30	1,204	277	631	127	860	249
1931–35	819	240	566	125	969	393
1936–39	625	227	471	106	1,017	531
1940–44	482	167	270	71	367	124
1945–49	258	101	157	41	381	130
1950–54	98	42	93	27	336	166
1955	84	36	53	24	332	173
1956	56	28	66	15	329	171
1957	48	20	53	22	358	183
1958	57	28	41	16	306	219

The averages for the years 1911 to 1939 are based on the 4th Revision of the International List. Figures for the years 1940 to 1958 are according to the 7th Revision.

Non-civilian deaths are excluded from September 3, 1939, for males, and from June, 1941, for females, to December 31, 1949.

* For years 1911 to 1939: "Aneurysm" (Code 96) of the 4th Revision List, based on arbitrary rules of assignment.

For years 1940 and after: "Aneurysm of Aorta" (Code 022) of the 7th Revision List, based on assignment by the certifying medical practitioner.